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ABSTRACT

The report evaluates Iowa's reorganization of mental health and mental retardation (MH/MR) services. Evaluation methods include a policy analysis of legislation, interviews with agency staff and consumer representatives, review of MH/MR Commission and Developmental Disabilities (DD) Council meetings, an opinion survey of county auditors, and review of county general allocation applications. Five topic areas are examined in terms of problem identification, legislative changes, and analysis of the standards or systems: (1) organization and administration of MH/MR/DD system; (2) coordination; (3) funding; (4) delivery of services; and (5) quality assurance. The final section reviews findings, including the findings that decision making and goal-setting functions within the system are strong while the monitoring and capacity-building functions are not; that there are marked differences in the degree of coordination experienced by different organizations within the system; that there appears to be uniformity of counties' prosperity tax burden and financial effort; and that deinstitutionalization is not significantly affected by the range of services available locally. Recommendations include improved data collection and management systems, and strategies for expanding the range of services to rural counties. (CL)

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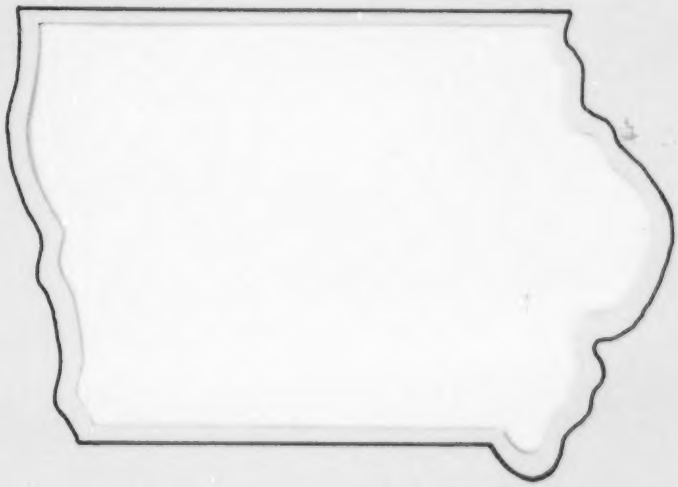

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PROGRAM EVALUATION OF

THE REORGANIZATION OF MENTAL HEALTH, MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES SYSTEM

September, 1984

Iowa Legislative Fiscal Bureau

Dennis C. Prouty
Director

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Program Evaluation Team Members

Pat Hipple, Project Manager
Daniel E. Ritter
John Sebold
Lynn Sevedge
Deb Westvold
Jonathan Neiderbach
Kathleen Colburn
M. Dwayne Ferguson
Thom D. Freyer

Copies of this report are available from the Program Evaluation Division of the Legislative Fiscal Bureau, State Capitol, Des Moines, Iowa 50319, (515)281-6766. A technical appendix is also available.

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SECTION I

INTRODUCTION

During the 1981 session, the 69th General Assembly adopted SF 572 (Chapter 78, 1981 Session Laws) culminating several years of legislative planning and decision-making. This legislation, referred to as the Mental Health and Mental Retardation Reorganization Act, sought to address a number of problems in the organization, planning, funding and delivery of mental health and mental retardation services in Iowa. The policy changes adopted in this legislation consolidated state management of the mental health and mental retardation services system, introduced new funding mechanisms, imposed new requirements for county planning, budgeting, and service delivery, and strengthened existing quality assurance mechanisms. Most of the bill was codified in Chapter 225C, 1983 Code of Iowa.

Problems Motivating the Reorganization

Much legislative effort, dating from the State Mental Health Institutions Study Committee in 1967-1968 and continuing through other interim study committees from 1971 through 1976, had been directed toward changing Iowa's mental health system. Many problems first surfaced during these interim study committees. During the 1977 interim, the 67th General Assembly contracted with the Human Services Research Institute (HSRI) for a study of the Iowa mental health system. Entitled "A Firm Foundation for Change" (January, 1978), this report outlined problems in service delivery, resource development, quality assurance, organization and administration, and planning. In March of 1978, the Governor's Task Force on Mental Health issued its report recommending changes in the funding of mental health services, the service delivery system, evaluation and accountability mechanisms, as well as other changes in state legislation. These reports, and the problems explicated in the reports, encouraged legislative pursuit of the reorganization. Legislative activities from 1978 through 1981 examined alternatives for change.

Specifically, problems included an unclear delineation of responsibilities in both the state and community mental health and mental retardation networks. Problems in the development and coordination of resources to support community mental health and mental retardation services were identified as impediments to the development of a comprehensive community service system. Initiatives for planning originated mostly with provider organizations. There was little collaboration with counties or other providers. This resulted in major gaps in community-based services and an inequitable distribution of services between counties. There was a lack of coordination and development of monitoring and standard-setting activities between the Department of Social Services and the Department of Health.

The Reorganization Legislation

The legislative purpose of the mental health and mental retardation reorganization is:

> ...to continue and strengthen the mental health and mental retardation services now available in the state of Iowa, to make these services conveniently available to all persons in this state upon a reasonably uniform financial basis, and to assure the continued high quality of these services. (Chapter 225C.1, 1983 Code of Iowa)

By passage of the reorganization, the General Assembly sought to address the problems in organization and administration, resource development and coordination, planning, service delivery, and quality assurance of the MH/MR/DD system. Five basic policy objectives are identified in the legislation:

1) to increase coordination and effectiveness in the relationships between organizations within the MH/MR/DD field;

2) to increase uniformity in the financial effort and property tax burden to counties of supporting mental health and mental retardation services;

3) to increase the range of community services conveniently available to county residents;

4) to decrease institutionalization in the care and treatment of the mentally ill and mentally retarded; and

5) to increase awareness of, use of, and satisfaction with activities designed to establish and enforce service quality and accountability standards.

To accomplish these broad policy objectives, the General Assembly created a number of coordination, financial assistance, and quality assurance mechanisms intended to restructure the mental health and mental retardation services "non-system" (Task Force, 1978) into a network of relationships between planners, funders, and providers. This restructuring was intended to clarify roles and consolidate responsibilities at both the state and county level for planning, coordinating, funding, and monitoring the delivery of mental health and mental retardation services. It introduced new state financial assistance programs to support expansion of community mental health and mental retardation services and promote uniformity in county financial effort and property tax burdens. New policy mechanisms provided for the continued development of standards for the treatment of the mentally disabled and clarified monitoring responsibilities.

Evaluation Methodologies

The legislation also requires the Legislative Fiscal Bureau to conduct a program evaluation of the efficacy of the reorganization and the contributions of the state agency assigned to implement the reorganization, the Division of Mental Health, Mental Retardation and Developmental Disabilities.

A variety of methodologies were used to evaluate the efficacy of the MH/MR/DD reorganization and the performance of the Division. A policy analysis of legislation adopted pursuant to SF 572 was followed by extensive interviewing of Division staff, staff of other state agencies, advocacy representatives, provider and consumer groups. Information was gathered through review of MH/MR Commission and DD Council meeting minutes and by a review of Divisions documentation files and state institution data files. An opinion survey of organizations within the MH/MR/DD system was conducted. A financial survey of county auditors and extensive review of county general allocation applications were also conducted. This document is the final report of findings of the LFB program evaluation.

SECTION II

ORGANIZATION AND ADMINISTRATION OF THE MH/MR/DD SYSTEM

Problem Identification

Problems in the organization and administration of mental health and mental retardation services had broad impact on the planning, funding and delivery of mental health and mental retardation services at the state and community levels. Both state and community mental health and mental retardation networks were characterized by an unclear delineation of responsibiiities that led to overlapping responsibilities and poor working relationships. As a result, activities were uncoordinated and it was difficult to hold any organization accountable for its contributions (HSRI, 1978, p. 208).

Prior to reorganization the state administration consisted of three separate agencies with responsibilities in the mental health area. The Mental Health Authority was the designated state agency authorized to receive federal funds; the MHA provided the Community Mental Health Centers with technical assistance and training. State institutional services were administered by the Division of Mental Health Resources of the Department of Social Services. The Governor's Mental Health Advisory Council was established in response to a recommendation in the 1978 Governor's Task Force Report, primarily to review the mental health system and recommend the most effective form of mental health reorganization. Many other state agencies, along with county boards of supervisors, had responsibilities in the mental health, mental retardation and developmental disabilities service systems.

Prior to the reorganization no single agency was given the responsibility and authority to coordinate state and local mental health and mental retardation activities. Initiatives for planning originated mostly with provider organizations and showed little collaboration with counties or other providers. In addition, counties had typically been excluded from state planning processes. This impeded the development of a comprehensive, coordinated county-based system of services.

The separatist organizational views of the state agencies did not allow an overall system perspective. As a result, the parochial interests of the various agencies maintained barriers to effective coordination and collaboration (HSRI, 1978, pp. 209-218). The lack of a policy direction resulted from the fragmentation of influence and authority of key state agencies with planning responsibilities. This inhibited the ability of state government to provide system leadership in a forum for discussion of priorities and plans (HSRI, 1978, pp. 212-6 & 231).

Summary of Legislative Changes

A policy objective of the Reorganization Act was to increase coordination and effectiveness in the relationships between organizations within the MH/MR/DD field. The organization that was developed by the legislation maintained a good deal of county control within the MH/MR/DD system. Many of the interorganizational relationships revolve around planning and funding activities. The system that is developing should become a checks and balance system in which the counties initiate the planning process and the MH/MR Commission approves plans that are consistent with state priorities.

The current system consists of at least four different functional groups, (1) state commissions, councils and boards, (2) state agency staffs, particularly the Division of Mental Health, Mental Retardation and Developmental Disabilities, (3) county governments and boards, and (4) service providers. The complexity of the system is evidenced by the large number of organizations involved.

State Commissions, Councils and Boards. The MH/MR Commission establishes necessary administrative rules relating to mental health/mental retardation programs, advises on administration of state plans, assures that proper appeal procedures are available, evaluates funding, monitors service providers and services and reports to the Governor and the General Assembly about those services. The MH/MR Commission coordinates planning with the DD Council, Health Department and other state agencies.

The Governor's Planning Council for Developmental Disabilities was created by the federal government to encourage interagency coordination to ensure that the needs of the developmentally disabled are met. The responsibilities of the Council are determined by federal statute and include advocacy and planning for the developmentally disabled.

Other state agency commissions and councils have policy-making authority for their respective agencies. The Human Services Council was established by state statute to act in a policy-making and advisory capacity to the Department of Human Services. While they do not have responsibility for setting policy in the area of mental health, mental retardation and development disabilities, they do approve the budgets for these services as well as all other DHS programs and services. The Commissions of the Department of Substance Abuse, Health, Public Instruction, and the Board of Regents also have considerable policy responsibilities for services to the mentally disabled populations.

State Agency Staff. The Mental Health/Mental Retardation/Developmental Disabilities Division of the Department of Human Services was created to assume the responsibilities of the Mental Health Authority, the Governor's Mental Health Advisory Council, and the Division of Mental Health Resources within the Department of Social Services. In addition, responsibilities for the mental retardation and developmental disabilities systems were consolidated into the MH/MR/DD Division.

The central concern of the Division is developing an organized statewide network of mental health, mental retardation and developmental disabilities services. In addition, the Division has direct authority and administrative responsibility for the four mental health institutes and the two state hospital schools.

County Governments. County Boards of Supervisors are vested with the authority to make decisions about how the system will operate at the community level. They are responsible for purchasing mental health and mental retardation services, collecting the information to identify local needs, and planning for meeting those needs. Counties may either have the county board of supervisors, in conjunction with a mental health/mental retardation advisory board, or a separate coordinating board perform the required functions of planning, administration and funding of local services.

Service Providers. The service provider group is comprised of organizations which actually provide therapy, treatment, education, living arrangements, etc. to the mentally disabled. This group contains several types of organizations: four mental health institutes (MHI), two state hospital schools (SHS), thirty-two community mental health centers (CMHC), eight district and ninety-nine county DHS offices, licensed health care facilities including intermediate care, residential care, county care facilities, work activity centers, sheltered workshops, community hospitals with psychiatric wards, and independent and affiliated psychiatrists, psychologists, social workers, etc.

Analysis of the System.

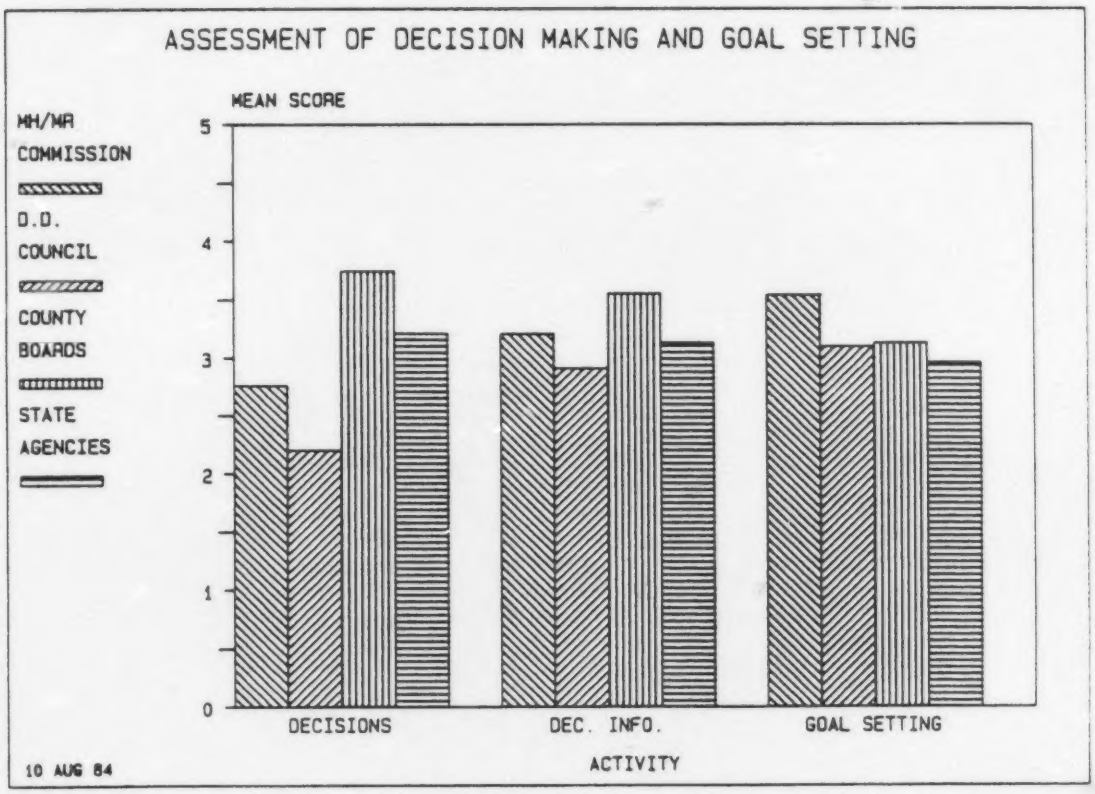
To evaluate the overall effectiveness of the MH/MR/DD system and to assess the efficacy of the system restructuring mechanisms implemented by the reorganization, agencies and organizations were asked to assess the decision-making, goal-setting, monitoring and capacity-building activities of the MH/MR Commission, the Developmental Disabilities Council, the County Boards and other state agencies.

Decision-Making Activities. Decision-making functions of these four key policy-makers were assessed, including the extent to which each made important decisions affecting the respondent organization, and the adequacy and accuracy of the information used to make those decisions. Generally, the extent to which an organization is affected by the decisions parallels the extent to which they perceive the information used in the decision-making process to be adequate and accurate. While all four decision-makers were viewed as using equally adequate and accurate information to some or a large extent, the county boards received higher average scores than the other groups.

There is little difference in perceptions of the decision-making activities of the four groups by different organizations within the system. The county boards received the highest ratings both on making important decisions and on using adequate and accurate information. Other State Agencies were perceived, particularly by Work Activity Centers and ICF/MRs, as making important decisions that affected them to a large extent; ICF/MRs and Work Activity Centers are dependent on licensure and/or state funding from the Department of Health and the Division of Social Services in DHS, respectively. It would appear that most of the respondent groups viewed these types of decisions as more important to their agencies than the policy decisions made by state agencies.

The DD Council was perceived as making decisions of little importance and received the lowest score from most of the respondent groups. The MH/MR Commission and Other State Agencies were both viewed as making decisions that were of some importance.

EXHIBIT 1



Goal-Setting for the MH/MR/DD System. The responsibilities for setting goals for the MH/MR/DD system were assessed by determining the extent to which each of the four policy-makers were perceived as goal-setters. Consistent with the intent of Chapter 225C, the MH/MR Commission was perceived by all groups as having primary responsibility for setting goals for the system. They were perceived as setting goals for the system to a large extent. The other three groups received slightly lower scores, and were perceived as setting system goals to some extent. Since the other groups in the system are also viewed as setting goals for this population, the ability of the MH/MR Commission to coordinate the goals and priorities of other state and local policy-making bodies within the MH/MR/DD system would appear to be quite important.

Monitoring of the MH/MR/DD System. The monitoring activities of the policy-making groups were assessed by determining the extent to which they monitored other agencies and the extent to which the tools they used produced accurate information. Monitoring can be both a formal process of quality assurance and fiscal accountability and an informal process of feedback and assessment and advocacy. In general, the ratings for monitoring activities of all of the four policy-makers were relatively low.

County coordinating boards/county supervisors and other state agencies were identified as performing the greatest amount of monitoring activities. Advocacy organizations indicated that they are not monitored by any group. All other organizations were monitored by at least one of the identified policy-making groups. The D.D. Council did the least amount of monitoring with only county boards and DHS respondents indicating that the Council monitored them to a little extent.

Predictably, state and regional agencies are only monitored to some extent by other state agencies; and patient advocates, who are appointed by local judges, are monitored to some extent by county boards. Provider agencies, DHS and county boards seem to be monitored by the greatest number of different groups.

County Boards are monitored the most by other organizations within the MH/MR/DD system. In addition, they are one of the primary organizations monitoring other groups in the system. Consequently, it would appear that there may be some delegation of the monitoring activities from the state to the County Boards.

While most of the groups did very little monitoring, all four groups were perceived as using tools that produced accurate information to some extent. Generally, the more an organization was monitored by a particular group, the higher they rated the accuracy of that group's tools.

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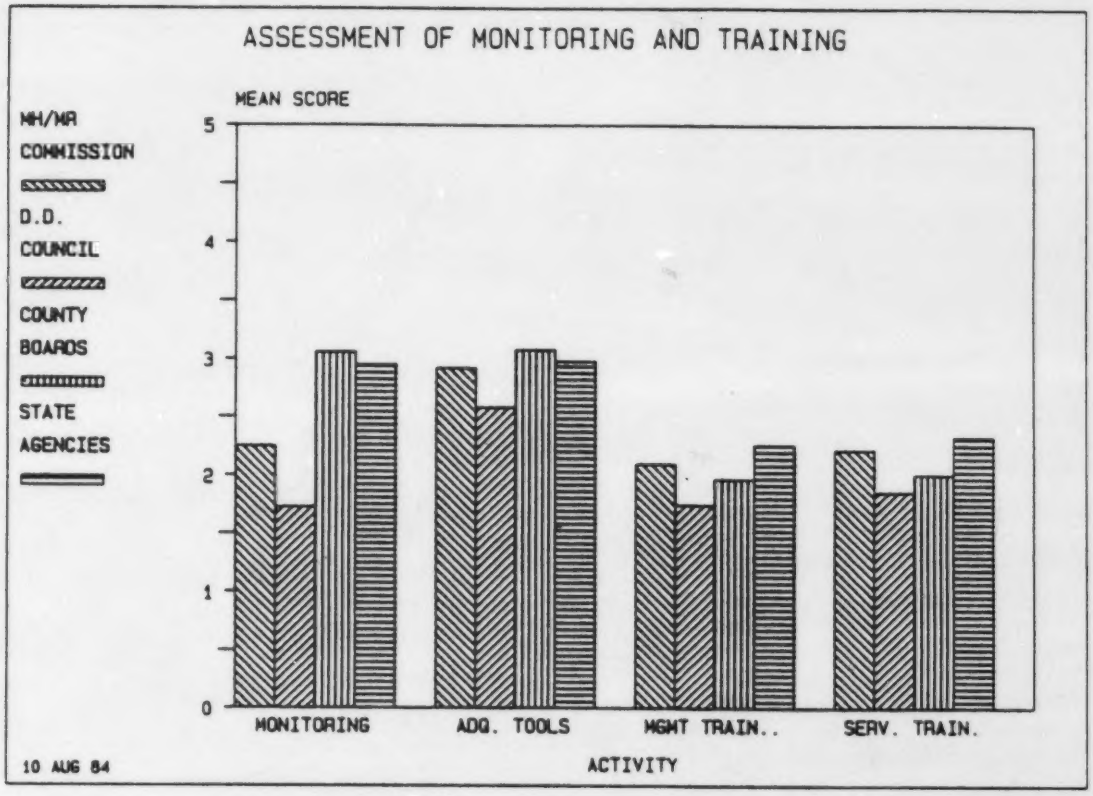


Capacity-Building. Capacity-building involves educating providers and the public about mental illness, mental retardation and developmental disabilities issues, providing resources, and advocating for the welfare of the MH/MR/DD populations. Even though MH/MR Commissioners are not required by Code to perform educational activities, or to act as advocates, they do both. The MH/MR/DD Division is required by the Code of Iowa to encourage and facilitate research and preventative educational activities related to the causes and treatment of mental illness and mental retardation. The county boards have no mandate to provide training or advocacy and the reorganization legislation was not specific in assigning such responsibilities to other state agencies.

The extent to which the four key policy-makers build capacity within the MH/MR/DD system was measured by assessing the amount of training and other assistance that agencies received. Activities assessed included training and assistance to improve both the management of programs and the quality of services offered. There is little evidence of educational or capacity-building activity among any of the key policy-makers.

The results indicate that little training or assistance is offered either in training for program management or service delivery. All four groups were identified as providing training and assistance to a little extent. It would appear the county boards and DHS receive most of this training. Some organizations indicated that they received more training and assistance from other state agencies, although the highest ratings were only "to some extent".

The MH/MR Commission appears to be fulfilling its role as goal-setter for the MH/MR/DD system. The counties continue to be the major decision-makers for mental health and mental retardation services, due largely to their funding decisions. Different organizations throughout the state appear to have similar perceptions of the decision-making, goal-setting, monitoring and capacity building activities of the main policy makers for the system. However, the strength of the ratings varies. Counties are maintaining an important role in the planning, funding and monitoring of local services as intended by Chapter 225C. Monitoring and capacity-building activities appear to be the weaker links, as both received fairly low ratings, indicating that little effort is being expended in these areas. It appears that most capacity-building activities are being conducted by provider and advocacy groups within the system, rather than by any of the key policy-makers.

Analysis of Division Performance

To evaluate the contributions of the Division, agencies and organizations within the MH/MR/DD system were asked to assess a number of Division activities and products. The activities or products assessed included: the FY 1983-1986 Iowa Comprehensive Plan, Annual County General Allocation Application Packets, Applicant Conferences, and the 1983 MH/MR Commission Annual Report.

Annual County General Allocation Application. The General Allocation Application that counties must complete in order to receive their share of the MH/MR Community Services Fund serves several purposes. In addition to providing the Division with financial and programmatic information on the types of services each county plans to provide in the upcoming year, completion of the application begins the annual planning process for the development of the Comprehensive State Plan. The applications contain information on the number of mentally ill and mentally retarded persons served with county funds, indicate priority service needs to which the general allocation funds will be directed, and identify service gaps. The information provided in the application is utilized in the preparation of the state plan document.

As expected, DHS and the county boards used the General Allocation application to the greatest extent. The majority of these organizations indicated that it contributed to their mission to a great extent. Provider-facilities and advocacy organizations used the application to some extent, while patient advocates and state and regional agencies used it only to a little extent.

Iowa Comprehensive State Plan for Mental Health, Mental Retardation and Developmental Disabilities. The 1983-1986 plan was prepared "in order to assess the history, current status, and future direction of the mental health, mental retardation, and developmental disabilities systems and services within Iowa." In addition to providing information, it serves as the state's applications for federal Developmental Disability and the Alcohol, Drug Abuse, and Mental Health Block Grants.

Use and importance of the Comprehensive State Plan ranked second to the general allocation application. Respondents indicated that they were familiar with it to some extent, but those who used it did so to a high extent. DHS staff used it to the highest degree, followed by county boards, provider-facilities, state and regional agencies and advocacy organizations. Patient advocates found the plan to be of a little use. While 59% of the providers-facilities that responded used the plan to some extent, they found it to be of little use in accomplishing their agency's mission. It would appear that the county planning process required to complete the general application has been more useful than the completed state plan.

MH/MR Commission Annual Report. Chapter 225C requires the Division Director to annually submit to the Governor and the General Assembly a report concerning the activities of the MH/MR Commission. Respondents indicated that they were familiar with and used this report a little, however, it did not contribute to their mission. County boards rated the report higher than any other group and used the report to some extent. While 69% of the DHS respondents used this report, 50% and less of the other respondent groups used the report to any extent.

Training Conferences. Chapter 225C.4(b) requires the Director to assist county coordinating boards in developing a program for community mental health and mental retardation services. To accomplish this, the division provided two types of training activities to enable counties to complete the county plan and held regional workshops to educate counties on the mental health and mental retardation funding streams. Chapter 225C also requires them to provide consultation and technical assistance to patient advocates in cooperation with the judicial system and care review committees appointed for county care facilities.

For purposes of analysis, the training conferences were grouped together into one category. 53% of the county boards indicated that they used the training conferences. They indicated that they used the conferences to some extent and that these conferences contributed to their mission to some extent. Only 29% of the patient advocates responded to the question on the use of the training conferences. Those who indicated that they had used the conferences, did find they contributed to their mission to a large extent. DHS and advocacy agencies also used the conferences to some extent, while providers-facilities and state and regional agencies used the regional training conferences to a little extent.

SECTION III

COORDINATION

Problem Identification

The lack of coordination impeded the development of more comprehensive community service systems. Poor coordination of ancillary community services to support mental health clients in the community was cited as a problem (HSRI, 1978, p. 156-7). A lack of resources and expertise to provide clinical or programmatic technical assistance to local mental health care providers was cited as a barrier to the development of new program modalities and therapeutic techniques. It was also noted that patient advocates (appointed by the judiciary to monitor the care and treatment of certain mental health clients) had not been adequately prepared for their role of assuring that clients' needs are addressed. (HSRI, 1978, p. 130).

Legislative Changes

The reorganization legislation sought to increase coordination and effectiveness in the relationships between the Division, other state agencies and state, regional and local organizations that serve the MH/MR/DD populations in Iowa. The Division was established in a central role to coordinate state policy planning related to the funding, delivery and regulation of MH/MR/DD services.

Chapter 225C of the 1983 Code of Iowa outlines the legal responsibilities of the Division for coordinating the MH/MR/DD system. These responsibilities require that a variety of organizational relationships be maintained by the Division. Duties of the Division include:

- Consulting with a variety of state departments and agencies in order to facilitate coordination of services provided to mentally ill, mentally retarded, and developmentally disabled persons in this state.
- Encouraging and facilitating coordination of services with the objective of developing and maintaining in the state a mental health and mental retardation service delivery system to provide comprehensive services to all persons in this state who need them.
- Promoting coordination of community-based services with those of the state mental health institutes and hospital-schools.
- Establishing suitable agreements with other state agencies to encourage appropriate care and to facilitate the coordination of mental health, mental retardation and developmental disabilities services.

To accomplish these mandates, the legislation created several mechanisms to facilitate and promote coordination of the MH/MR/DD system: 1) The MH/MR Commission, was established. 2) The county coordinating boards were designated as the planning authority for each county, and a clear liaison relationship with the Division was created. 3) The Division was authorized to prepare and administer a state MH/MR/DD plan based on county input. 4) The Division was assigned to administer the state community mental health and mental retardation services fund. 5) The Division was required to create and maintain a data collection and management information system for the MH/MR/DD system, and 6) Preliminary diagnostic evaluations of potential mental health institute admittees became a requirement.

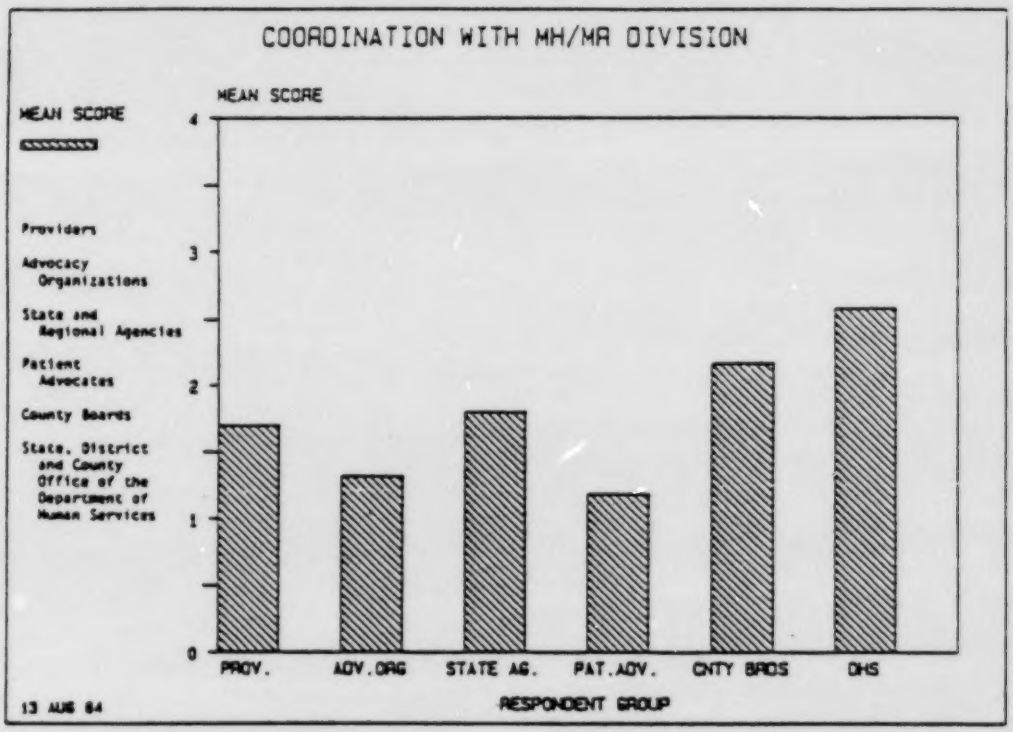
Analysis of Coordination

Coordination is an aspect of interorganizational relations that involves setting goals, identifying the action steps needed to reach those goals, specifying who will perform the actions and then carrying out these actions in a synchronized, efficient manner. Coordinated organizational relationships exhibit the following traits: joint activities are well timed and scheduled, task assignments are well planned, responsibilities are well defined and a singleness of direction has been achieved. These traits were used to assess the coordination performance of the Division.

There are marked differences in the levels of coordination of the various types of organizations with the MH/MR/DD system, as is illustrated in Exhibit 3. State and local offices of the Department of Human Services are most coordinated with the Division. Advocacy organizations and district court appointed patient advocates, on the other hand, are least coordinated with the Division. Coordination is based on the traits of interaction activities stated earlier, but a large number of advocates perceived no joint activities or interactions with the Division on which to base any measurement of coordination.

Based on our analysis of the Division's coordination of the MH/MR/DD system, levels of coordination are not influenced by the frequency of communication between an organization and the Division or the existence of disagreements or disputes with the Division. Neither are they influenced by the balance between power, empathy or trust in the system, the population served or extent of the variety and complexity of involvement of a participating organization.

EXHIBIT 3



The analysis identified five factors which appear to be key to optimizing coordination within this system: achieving consensus, formalizing relationships, the importance of contacts, using an equalitarian communication style and maintaining a reciprocal relationship with organizations in the system.

Consensus between the Division and system organizations is reached when there is agreement on the most important needs of the MH/MR/DD populations, the way services should be provided, the most important goals of the Division and the ways in which those goals should be accomplished. Based on survey findings, where higher levels of consensus exist, so does a higher level of coordination. Because there is very little difference in the levels of consensus of the various types of organizations within the system, attention to negotiating consensus and attaining agreement on goals will improve coordination across the board.

Formalization of relationships between the Division and the respondent's organization refers to the extent to which their relationship is mediated by a standing committee which follows standardized procedures and make decisions considered to be binding on the participants. The analysis found that coordination was significantly improved where a number of interagency committees exist to coordinate activities between the organizations and the Division, and when these committees have formalized agendas and the authority to make binding decisions.

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Reciprocity refers to the symmetry of the transactions among organizations. In the relationships between the Division and each organization in the system, resources can flow to both parties equally or in an imbalanced fashion. If either organization perceives an imbalance in the relationship, the interactions might be difficult to sustain. Resources to be shared in the MH/MR/DD system might include money, staff time, client referrals, consultation and technical assistance, visibility and goodwill, equipment and space, or documents and general information. The analysis detected that those organizations which experience a reciprocal relationship with the Division also experience higher levels of coordination.

Communication styles used between organizations can be directive, equalitarian, rule-oriented, direct and pragmatic or receptive. A directive style is demanding and willing to use power and authority to gain compliance or agreement. Equalitarian communication is free-flowing, friendly, mutually understanding, and stimulating of equal participation. By focusing on rules and systematic procedures, the rule oriented style gives much attention to defining situations or clarifying the approaches to a discussion. A direct style is brief and to-the-point, pragmatic and action-oriented. Yet a fifth style, receptive, is supporting of your ideas, accepting of your desires, complying with your point of view, and shifting responsibilities to you.

Nearly 44% of the organizations within the system experience the most typical communication styles of the Division as demanding, rule oriented or direct. Those relationships within the MH/MR/DD system that are marked by equalitarian communication styles are most conducive to higher levels of coordination, while other styles of communication did not seem to influence better coordination.

The importance of an organization's contacts with the Division to attaining their mission is the final factor which significantly influences coordination. The more important Division contacts are to achieving an organizational goal, the higher the level of coordination between the Division and organizations within the system will be. However, importance may be a factor over which the Division has no control.

Effectiveness of Relationships and Positive Assessments, the extent to which participants within the MH/MR/DD system judge their organizational relationships to be worthwhile, productive and satisfying, perceive the Division to carry out its commitments, and view the Division's personnel as competent and their performance adequate are important criteria for evaluating the Division. It could be assumed that the more coordinated a relationship is, the more likely it will be positively assessed and judged as effective. We found this to be true of the MH/MR/DD system and the Division. Relationships within the system that have a higher level of coordination are more effective relationships and assessment of the Division is higher. In addition, importance, equalitarian communication and consensus were significant factors in predicting the effectiveness and positive assessment of the system.

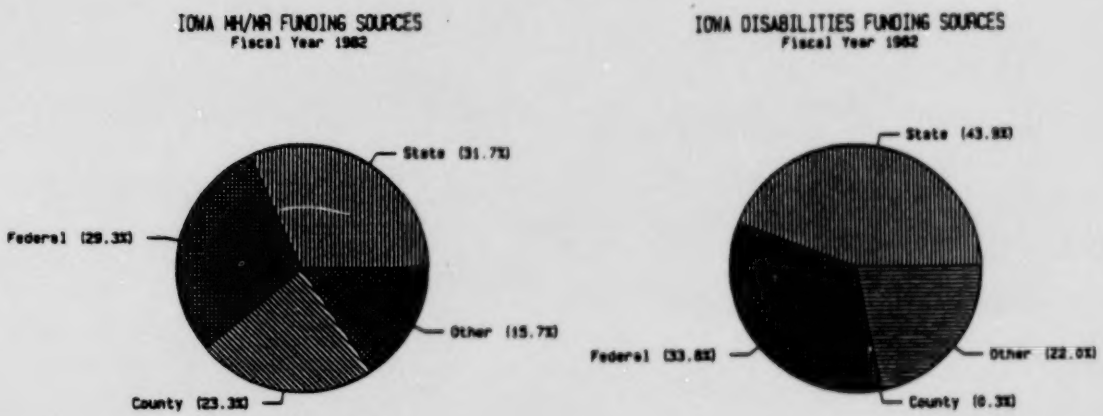
SECTION IV

FUNDING

Problem Identification

The MH/MR/DD system is funded by numerous sources, as Exhibit 4 illustrates. Titles XIX and XX of the Social Securities Act, federal block grants, and the Veterans Administration contribute federal dollars to the system. A variety of state agencies, including the Board of Regents, Health Department, Department of Public Instruction, Department of Substance Abuse, Civil Rights Commission, and Department of Human Services contribute state funds. United Way, insurance companies, private pay individuals, and others add more money to the system.

EXHIBIT 4



At the county level, the traditional reliance on property tax sources for financing the mental health and mental retardation service system locally was seen as a problem. The fiscal stress placed on this source limited its ability to support expansion of the community service system to a comprehensive level (Task Force, 1978, p. 71). Prior to the reorganization, state aid was limited to providing a discount for institutional services and partial reimbursement for certain patients residing in County Care Facilities. The narrow restrictions on these funds were perceived to be inflexible and provided few opportunities to expand or create needed services. Few federal sources of funds had been developed to provide start-up costs for new services.

Summary of Legislative Changes

The reorganization sought to increase uniformity in the financial burden and effort of counties in their support of mental health and mental retardation services. The legislation contains three major financial assistance mechanisms intended to increase uniformity in the financial burdens to counties and reduce such heavy reliance on local county property tax:

1) the community mental health and mental retardation services fund;

2) the state reimbursement for local inpatient mental health treatment; and

3) federal fund granting authority.

The Community Services Fund consists of an 80% General Allocation fund which is distributed to eligible counties on a formula basis and a 20% Special Allocation fund which is a grants program for demonstration projects and new service start-up dollars. To be eligible for money from the State Community Mental Health and Mental Retardation Services Fund, a county must (1) continue to raise by county levy and expend for mental health and mental retardation services an amount of money equal to what they spent in fiscal year 1981, (2) submit an application containing a plan for comprehensive MH/MR services which explains the general allocation procedures and demonstrates availability and accessibility of services, and (3) expend a portion of its money to affiliate with a community mental health center unless granted a waiver by the MH/MR Commission.

A formula divides eighty percent of the services fund among all 99 counties:

$$\text{County's General Allocation} = \frac{\frac{1}{2}\ (\text{General Allocation})}{99\ \text{counties}} + \frac{\text{County population}}{\text{State population}} \times \frac{1}{2}\ (\text{Gen Alloc})$$

The first appropriation to the Community Mental Health and Mental Retardation Services fund was $1,360,000 for FY 1983. Since that year the appropriation has increased $1,000,000 annually to a $3,360,000 appropriation for FY 1985. Each county was assured that state funding would be equal to or greater than the amount they had received prior to the establishment of the Community Services fund. In FY 1983 the amount that each county received ranged from $6,566 to $98,926 with an average of $11,500 received per county for the general allocation and $2,200 from special grants awards.

The Partial Reimbursement Program has not been funded since 1982, but when it operated, it provided partial state reimbursement to counties for costs of local inpatient treatment paid for by the county in lieu of admitting the client to a state mental health institute. The partial reimbursement mechanism was intended to increase the use of community service options in preference to state institutional treatment.

Federal Fund Granting Authority was assigned to the MH/MR/DD Division. The Division is charged with the responsibility to seek and obtain available federal funds to support the purposes of the mental health and mental retardation reorganization, as well as to administer the funds already available. The major sources of these funds are Title XIX, the federal Developmental Disabilities grant, the Community Support Program grant, the federal Mental Health Manpower grant, and the MH portion of the Alcohol Drug Abuse and Mental Health Block Grant.

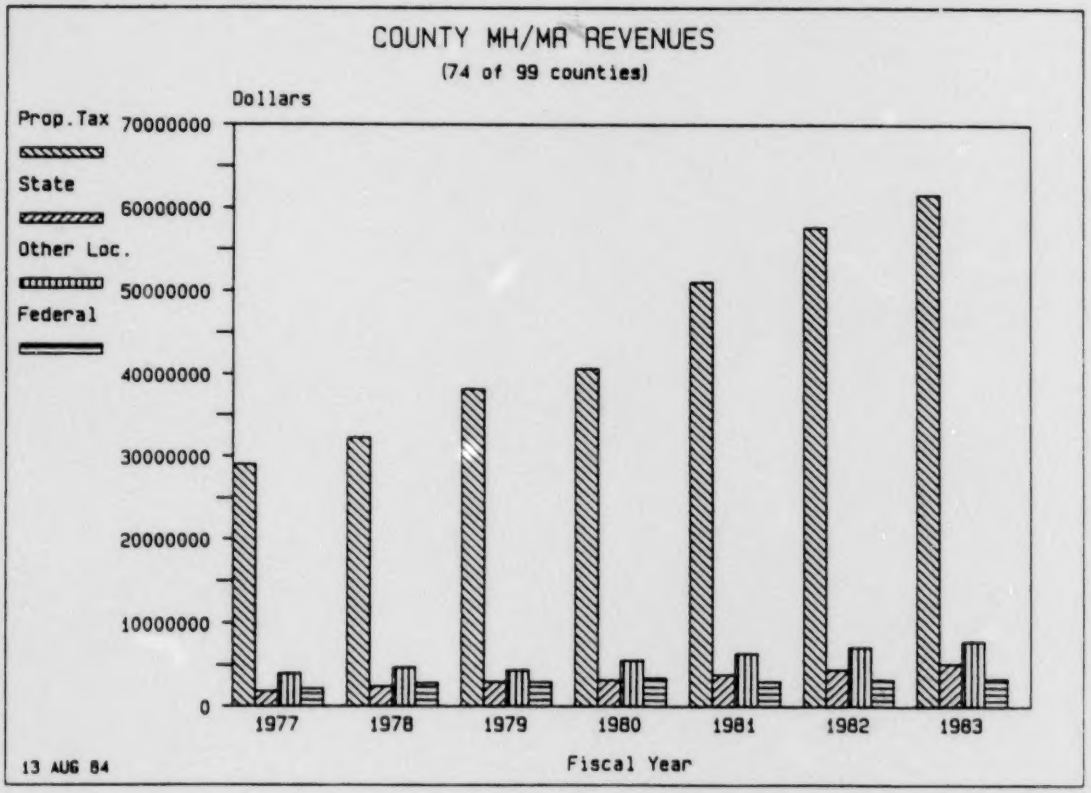
An Analysis of MH/MR Financial Data

County auditors supplied the LFB with financial data listing county revenues and expenditures for MH/MR/DD services. They identified four revenues sources: county property tax, state dollar receipts, other local revenues and federal funds. In addition, seven expenditure categories were delineated: Mental Health Institutes, State Hospital Schools, Community Mental Health Centers, Community Intermediate Care, County Care Facilities, Residential and Non-Residential Facilities.

Effort and Burden. One objective of the reorganization was to increase the uniformity of county financial effort. There was an assumption that counties of different population sizes are paying different per capita costs for MH/MR services. To the contrary, per capita expenditures -- financial effort -- has been approximately equal throughout the last seven years. There is little or no relationship between county population size and effort. Likewise, the average financial burden -- the amount levied and spent for MH/MR services per $1,000.00 assessed valuation per capita -- has also been approximately equal during this period. There appears to be no significant relationship between population and financial burden either.

Revenues. A breakdown of the MH/MR revenues to counties reveals that there has been a steady increase in all county revenue sources for MH/MR services, but there have been no significant changes in the proportional share of revenues from the various sources. County property tax has remained the major source of revenues, accounting for between 76% and 79% of the MH/MR revenues from 1977 to 1983. Federal fund revenues for the counties contributed 4% to 7% per year, state funds 5% to 7% per year, and other funds 9% to 10% per year. Efforts to offset county property tax burdens with state dollars from the community services funds have not been realized.

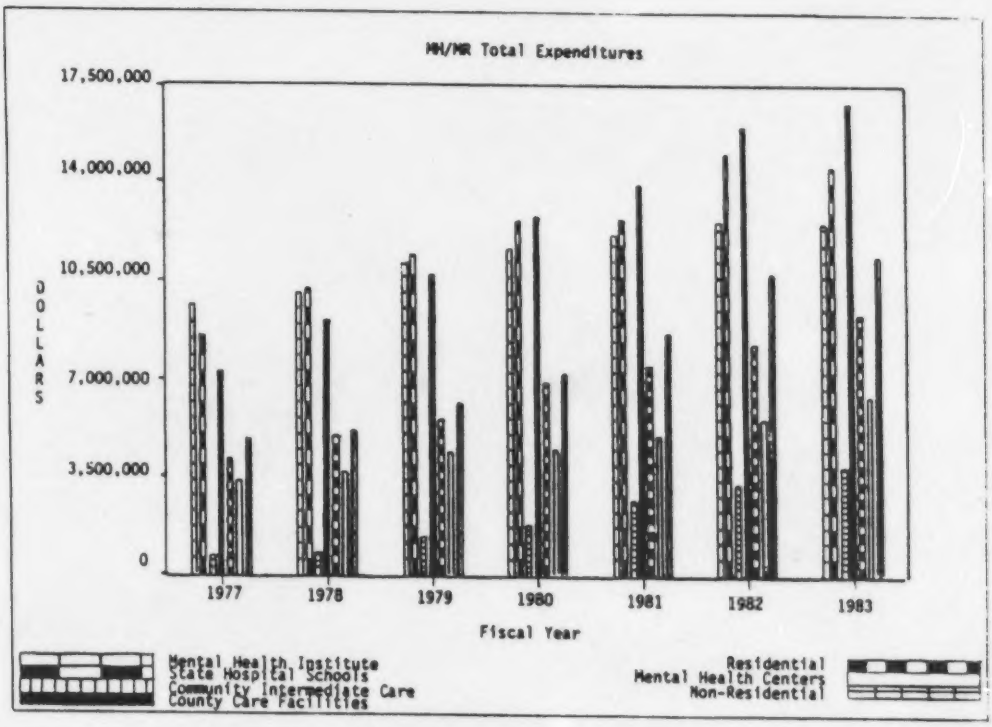
EXHIBIT 5



Expenditures. Exhibit 6 illustrates the shifts in expenditures from 1977 to 1983 for seven categories of service. It is clear that expenditures have increased in all the categories, with some service categories increasing at faster rates then others.

EXHIBIT 6

TOTAL COUNTY EXPENDITURES
FOR MENTAL HEALTH AND RETARDATION SERVICES



As illustrated in Exhibit 7, when expenditures are adjusted for inflation, little real increase is evident. Real county expenditures in 1983 were virtually unchanged from their level seven years earlier. Because of the tight fiscal situation during this period, this has generally been true of state and local spending nationally, as well.

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EXHIBIT 7

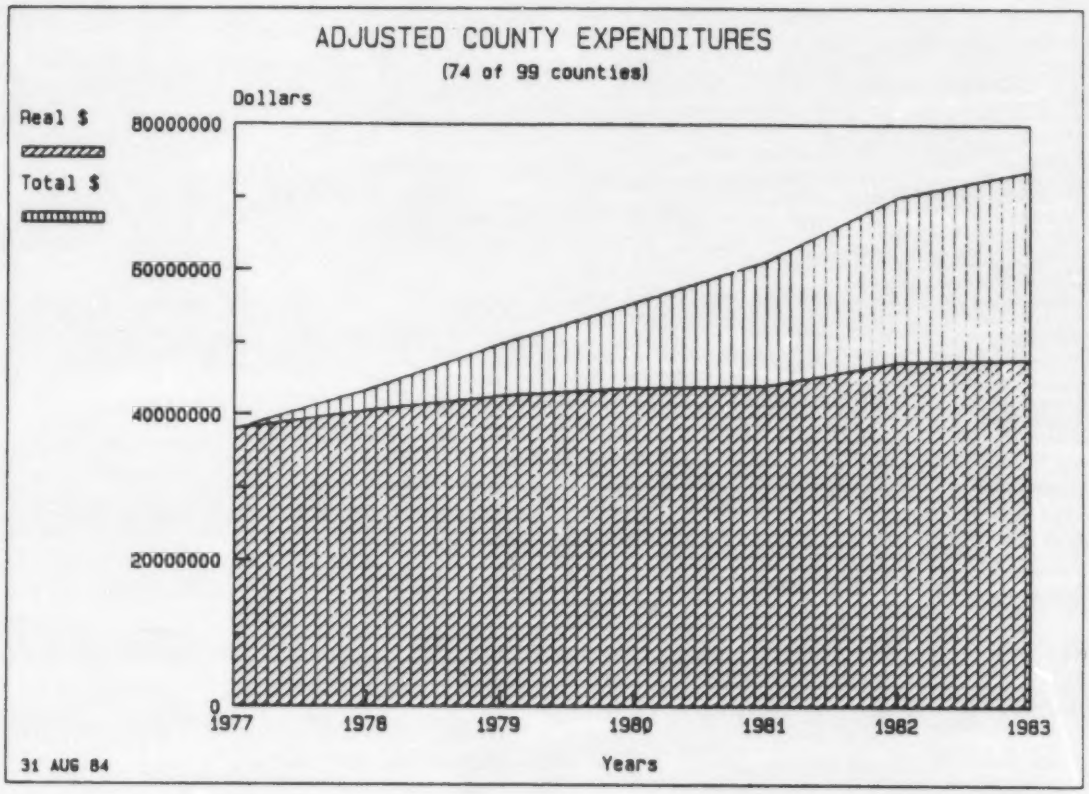
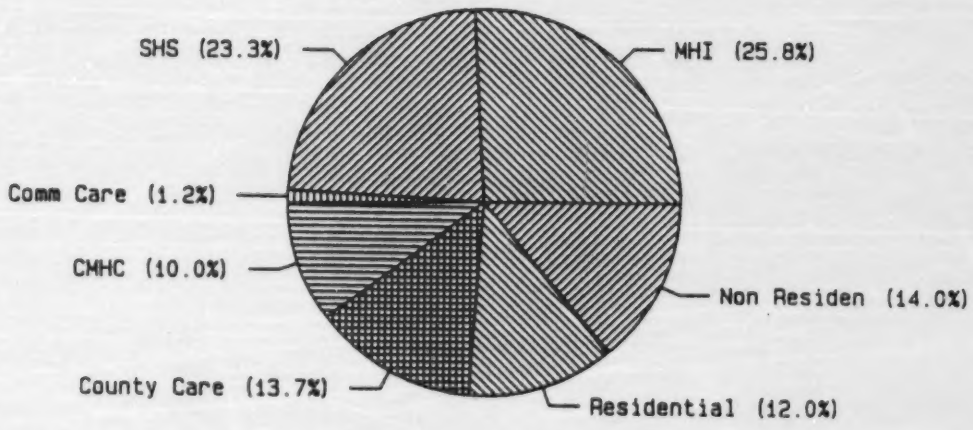


Exhibit 8 illustrates that percentage expenditures for the services of the Mental Health Institutes have steadily decreased from 25% of the total expenditure in 1977 to 17% of the total expenditure in 1983. Expenditures for State Hospital Schools have decreased at a slower rate, from 22% in 1977 to a low of 19% in 1983. Mental Health Centers have consistently taken between 8% to 9% of the MH/MR expenditures per year, indicating little change in percent expenditure.

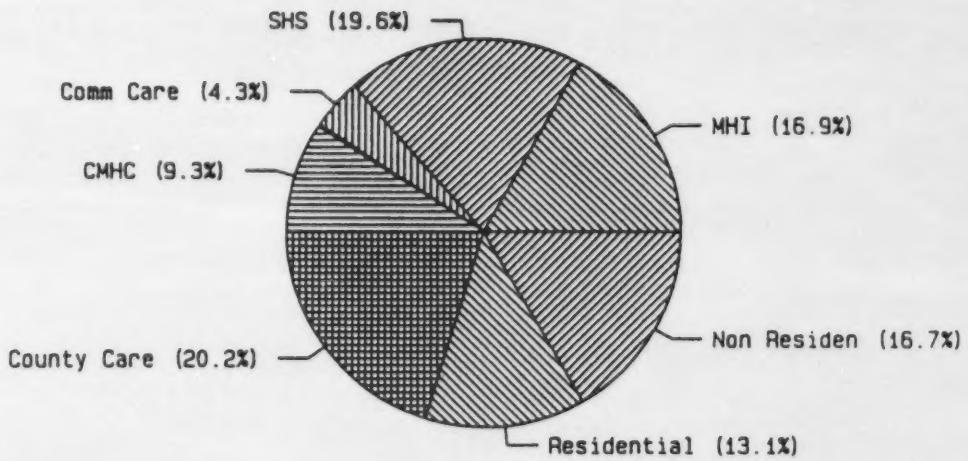
On the other hand, four categories, Community Intermediate Care, Residential, County Care Facilities and Non-Residential have all increased in percent of total expenditure. This suggests that counties are attempting to maintain and possibly increase community services. In general, counties are using a smaller percentage of their total MH/MR dollars for Mental Health Institutes services and are shifting money to county based inpatient programs.

EXHIBIT 8

COUNTY EXPENDITURES
Fiscal Year 1977



COUNTY EXPENDITURES
Fiscal Year 1983



SECTION V

DELIVERY OF SERVICES

Problem Identification

While local mental health programs were considered "fundamentally healthy" and the Mental Health Institutes had a "reputation for providing good care", major problems existed in service delivery (HSRI, 1978, pp. 1-3). There was an inequitable distribution of community mental health and mental retardation services between counties and there were major gaps in community service systems, particularly in counties of smaller population (LFB, 1980 & HSRI, 1978, pp. 90-99). Problems in the coordination of service delivery were evidenced by poor linkages between community and institutional programs and by the lack of case management for the mentally ill (HSRI, 1978, pp. 100-131).

Legislative Changes

The Reorganization sought to expand treatment alternatives and strengthen community mental health and mental retardation services. The legislation reaffirmed the policy of deinstitutionalization by continuing to re-orient mental health and retardation service delivery from the institutional to the community setting. It also implemented preliminary diagnostic evaluations (PDE). PDE is a process of screening individuals in their home community prior to voluntary admission to an MHI to determine appropriate treatment needs, specifically, whether state institutionalization is the most appropriate placement for the individual. Secondarily, PDE is intended to remedy weak linkages between institutional and community programs

Analysis of Range of Services

The service definitions used by the Division to identify a comprehensive array of services were originally developed from schemata used in federal legislation to define that array of services to be provided by Comprehensive Community Mental Health Centers and Community Mental Retardation Facilities in order to receive construction and staffing dollars through the Mental Retardation Facilities and Community Mental Health Centers Construction Act. The current list of services which comprise, according to the Division, a comprehensive array of mental health and retardation services is presented in Exhibit 9.

EXHIBIT 9

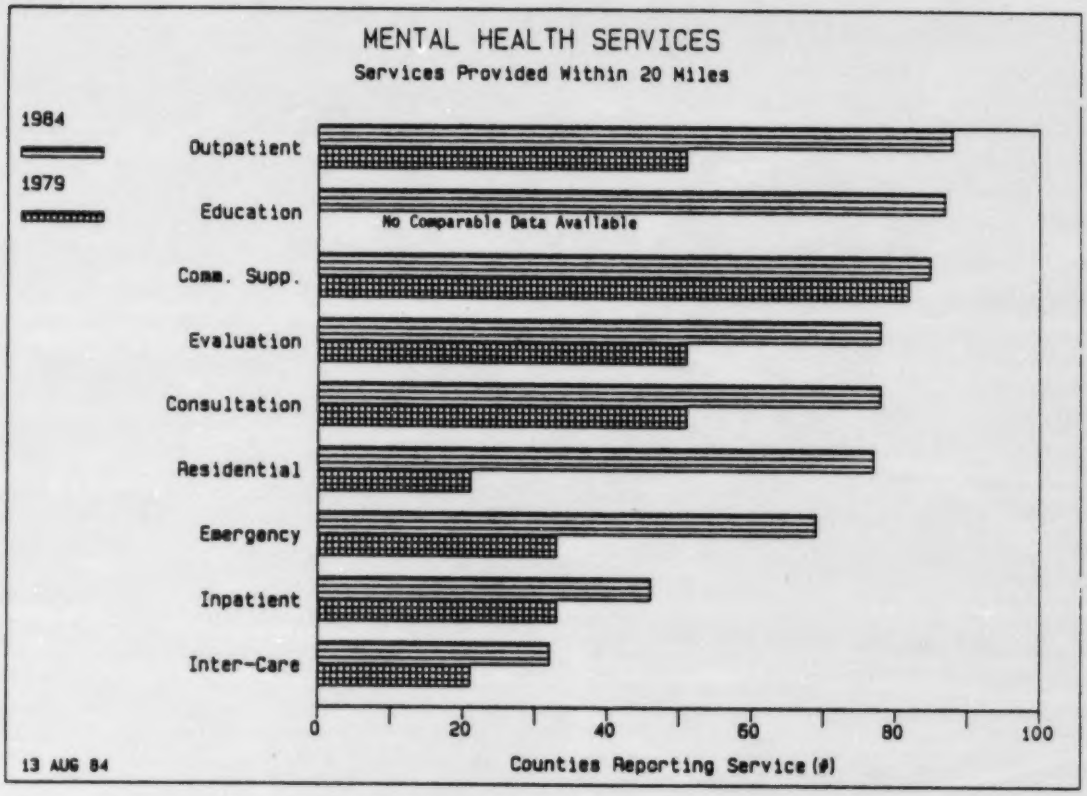
Mental Health and Retardation Services

Mental Health Services	Mental Retardation Services
Outpatient	Diagnostic and Evaluation
Intermediate Care/ Partial Hospitalization	Community Support
Residential	Prevention
Inpatient	Treatment
Community Support	Specialized Living Arrangements
Emergency	Educational/Functional Academic
Evaluation	Social Adjustment - Development
Consultation	Vocational
Education	

It is the purpose of Chapter 225C, 1983 Code of Iowa, "to continue to strengthen the mental health and retardation services in the state of Iowa, and to make these services conveniently available to all persons in the state upon a reasonably uniform financial basis, and to ensure the continued high quality of these services." Ultimately, every mechanism in the reorganization legislation was adopted in pursuit of this. In order to assess the extent to which mental health and retardation services are conveniently available to county residents, an inventory and evaluation of service proximity were conducted by the LFB. The inventory was accumulated by reviewing the county applications, surveying organizations, verifying service directories and interviewing Division staff. The results of the inventory are examined below.

Exhibit 10 compares the findings of a 1979 LFB inventory of services with the present LFB inventory. The occurrence of designated mental health services within twenty miles of the county seat is charted. In most cases, available services will be located in the county seat as it is the area of highest municipal population. The county seat is often centrally located which makes it a good indicator of distance from which to measure service availability.

EXHIBIT 10



From 1979 through 1983, the number of services available to counties within 20 miles has increased for each service category; the residential service range has increased the most. The data reveal that outpatient services are the most frequently provided mental health service, available within 20 miles to 88 of 99 counties. As in 1979, emergency, inpatient, intermediate care and partial hospitalization, and residential services continue to be the four services most in need of development in order to complete a comprehensive system. On a continuum of care basis, the availability of these services may be more crucial for deinstitutionalization to succeed.

Judgements concerning changes in the range of services should be made with caution, however. Use of the county plans was limiting because counties encountered problems in their identification of services on the Division's application. There was confusion over service definitions, and the meaning of "available" services. A major drawback is that while availability of service may be recorded across counties, the level and quality of those services is not. For example, emergency services may be provided as indicated either by a psychiatric facility or crisis telephone counseling. Urban mental health centers may provide regularly scheduled evening service with a variety of staff, while rural counties may have satellite services by appointment only. In some areas of the state, the available services

are described as "paper thin". While it appears clear the range of services has increased since 1979, the current definitions for the array of mental health and mental retardation services differs from service titles and definitions used in 1979. Mental health service categories were compressed from 12 to the present 9; elderly services, children services, drug abuse, and alcohol services are no longer defined as separate mental health service categories. And mental retardation categories were compressed from 16 to 7 with a new service introduced bringing the total to 8. Continual change in these service definitions makes it very difficult to track service development over time. At present, the commission is working on yet another revision of the service taxonomy which will distinguish settings and clients for the generic services.

It should be highlighted here that this inventory measures a county's perception of service availability. The Division indicates that there are several categories of services available in each county through the local DHS office and therefore full availability should have been recorded. However, if counties are not aware of the availability of a these services, their ability to plan for service delivery is impeded.

Factors Which May Effect Service Availability. The 1979 LFB Inventory examined certain characteristics of counties to determine their influence on service availability. These factors included county population, population density, local property values, assessed valuation, and amount of levy. At that time, it was apparent that as population, density, assessed valuation and levies increased, so too did the proximity of mental health services. Exhibits 11 and 12 demonstrate that these factors are still relevant today.

Limited population negatively influences service proximity, as Exhibits 11 and 12 demonstrate. It is convenient to look at the 10 highest and 10 lowest populated counties, as these provide clear evidence of the relationship that exists between population and service proximity. Eight of the most populated counties in Iowa have the full array of nine comprehensive mental health services within twenty miles of the county seat. They comprise about 40% of the counties which have all services. Meanwhile, five of the ten least populated counties in the state have fewer than four mental health services.

The relationship between population and service proximity exists also for the mental retardation data. Eight of the most populated counties which provide the full range of MR services constitute about 50% of those counties with all services available. At the other end of the scale, five out of ten least populated counties have fewer than two mental retardation services.

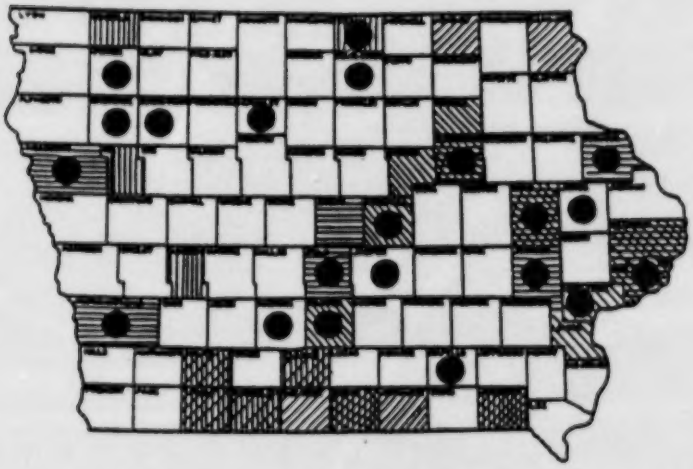
Generally, the average number of services provided within twenty miles increases as the size of the population increases. The largest counties have an average between eight and nine services compared to an average of three to four in the smallest populated counties.

Twenty-one counties provide a full range of mental health services within their county and they account for about 50% of the states population. Mental retardation services are provided within counties which represent about 42% of the states population.

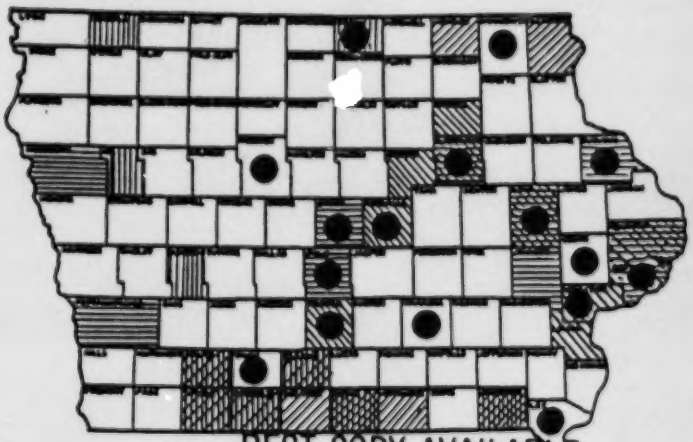
EXHIBITS 11 and 12

SERVICES WITHIN TWENTY MILES OF THE COUNTY SEAT
1984

Mental Health Services



Mental Retardation Services



10 most populated

10 least populated

10 highest median income

10 lowest median income

comprehensive array of services available

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Socio-economic factors also influence the range of community services. As stated by HSRI, "outside of the four mental health institutes, the development and support of a more broadly-based community system has been almost totally the result of local initiative and concern. This is different from states who have elected to impose structure and content from the top down through comprehensive legislation and generous state funding incentives. Instead, in Iowa, local mental health programs have most definitely been a grass roots effort". The "development of community based programs to serve deinstitutionalized populations did not take place in an orderly or systematic manner. Rather, these programs emerged in response to a variety of social, political, and professional motivations" (Rutman, pg. 73).

The association between assessed property value and county population is strong. Counties with lower populations generally experience lower property values. Although urban areas or populous counties have a higher base against which to levy property taxes than rural counties, the expenditures per person and levy per 1000 dollars of assessed value are not related to county population size. Instead, the amount expended per person for mental health and mental retardation services is approximately equal among counties. In terms of using per capita tax burdens as a criteria for financial assistance, comparison was made of the rankings of counties based on service gaps versus ranking on financial burden. No significant relationship was found. That is to say, counties with large service gaps are not found to spend considerably more or less than counties with full service, on a per capita basis.

Imposing a criterium of twenty miles to judge service proximity and service availability fails to credit counties that have formed a consortium for service provision in order to overcome problems associated with economies of scale. Although population density may make it possible for urban counties to have services within a 10 mile radius, rural counties may need to view their service delivery area as extending beyond county boundaries. Several counties may need to link together to provide the most cost effective service. For example, one county supports a mental health center located within its county seat while depending on a neighboring county for services of a work activity center. Another possible alternative is for a county to rely on services from a "circuit rider" from a main office located some miles away.

To counter arguments that a 20 mile criterium may be too restrictive, an optional criterium of fifty miles was used to compare service proximity and availability. (Services fifty miles from the county seat would necessitate a client travelling 100 miles round trip to access the service). Exhibit 13 indicates the number of counties that lack certain services within a 50 mile radius. More than half of the counties are without intermediate care/partial hospitalization services and over 20 counties are without inpatient mental health services within 50 miles. An examination of mental retardation services reveals that over 43 counties do not have vocational services, more than 30 counties lack diagnostic/functional academic and prevention services and over 20 counties are without community support and specialized living arrangements within 50 miles. The most striking relationship is that nine of the ten counties with the lowest median family income are among the counties without full availability.

EXHIBIT 13

Number of Counties Lacking MH and MR Services Within 50 Miles

Mental Health Services		Mental Retardation Services	
Intermediate Care/ Partial Hospitalization	51	Vocational	43
Inpatient	22	Prevention	36
Emergency	16	Educational/Functional Academic	34
Community Support	15	Diagnosis & Evaluation	32
Education	13	Community Support	26
Consultation	7	Specialized Living Arrangements	25
Evaluation	6	Social Adjustment & Development	10
Residential	6	Treatment	6
Outpatient	2		

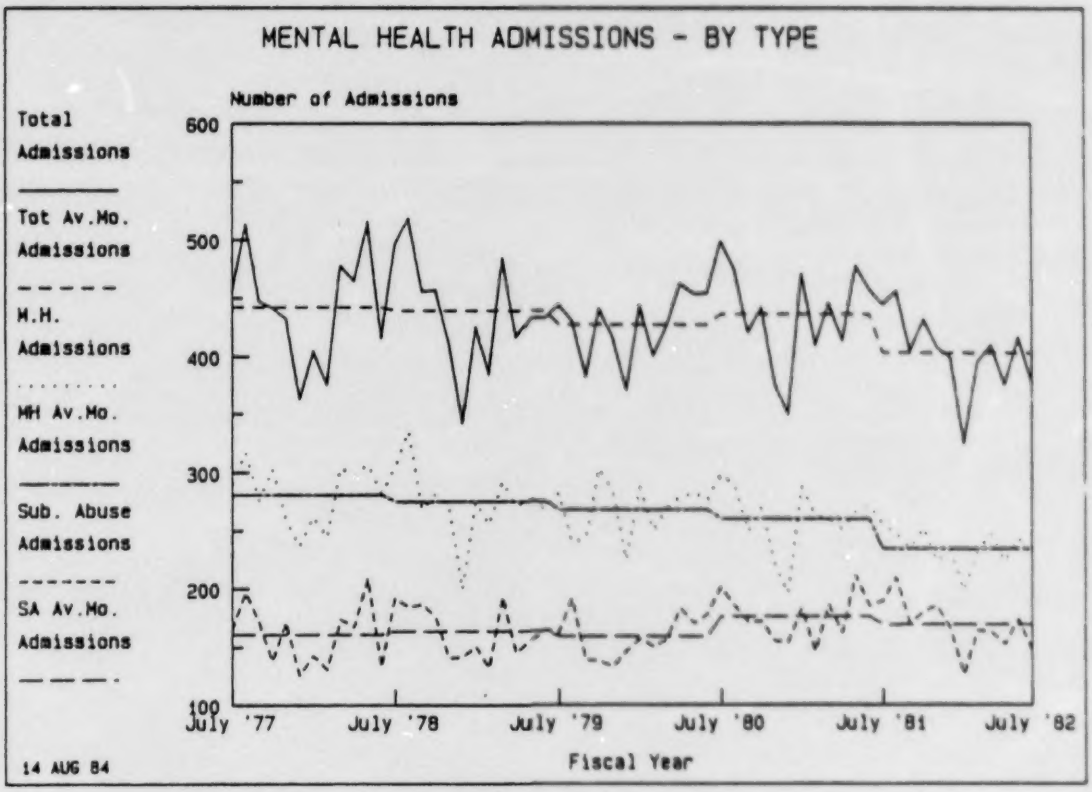
Analysis of State Institutionalization and PDE

Deinstitutionalization efforts require preventing inappropriate admissions and reducing readmissions. They also require improving conditions, care and treatment of patients in institutions, preventing unnecessary retentions in institutions, and finding and developing appropriate alternatives in the community for people who do not need to be in institutions. Preliminary diagnostic evaluations were intended to reduce the number of admissions to state mental health institutions, to reduce the lengths of stay of institutionalized

individuals, and to facilitate treatment of the client in the community, thereby avoiding institutionalization. To be eligible for state financial assistance, each county is required to implement PDE. Some counties have all or some evaluations performed by a community service provider; some have all evaluations performed by the state mental health institutes; still others combine local PDE during the day with MHI-PDE during after-hours.

Preliminary diagnostic evaluations have been implemented in many counties since 1982, but whether they influence deinstitutionalization is uncertain. As illustrated by Exhibit 14, there has been a continual decline in the number of state institution mental health admissions from 1977-1982. System changes were implemented that had an effect on admission rates. Changes in Title XX, the opening of Sydney Sands and Broadlawns West in Polk County and closure of Hope Hall at Clarinda, the discontinuation of children and adolescent services at Clarinda and Mt. Pleasant with the concomitant transfer of young clients to Cherokee and Independence have all had a more noticeable impact on admission declines than has the reorganization or the implementation of PDE.

EXHIBIT 14



Several statistical analyses were conducted to assess whether there is an association between county mental health financial expenditures and the rate of institutionalization. It was anticipated that as local county funding initiatives increase, admission rates to the state MHI would decline. This assumption was not supported by the data. We found no significant relationship between county financial efforts and admission rates. Likewise, we anticipated that as the range of county services increased, the county's admission rates would decrease. But again no significant relationship was detected.

Lengths of stay, another indicator of deinstitutionalization, could not be tracked in the MHI data with any confidence. A change in definitions of release and separation make it impossible to compare differences in lengths of stay over the various years. In addition, accurate admission, length of stay and average daily census data were not available for our analysis from the State Hospital Schools.

Only two years of data are available to assess the PDE and the reorganization's impact on deinstitutionalization. Further tracking of admission rates over the next several years as well as comparing changes in substance abuse admissions following the pending implementation of PDE for substance abuse, should provide stronger evidence of the efficacy of PDEs.

SECTION VI

QUALITY ASSURANCE

Problem Identification

Problems in assuring the accountability of providers and quality of services to the mentally ill or retarded negatively affected the range and level of service elements available in some provider facilities. There was a lack of appropriate programmatic and accountability standards for Community Mental Health Centers, County Care Facilities and Residential Care Facilities, and other facilities that provide services to the mentally ill or retarded. Monitoring and standard-setting by the Department of Social (Human) Services and the Department of Health for County Care Facilities was poorly coordinated. It was also noted that providers lacked incentives to comply with standards and the state monitoring agencies lacked authority to enforce compliance (HSRI, 1978, pp. 180-201).

Legislative Changes

There are numerous agencies involved in the accreditation and quality assurance process for the MH/MR/DD system. For example, the Department of Health licenses the state hospital schools which are administered by the MH/MR/DD Division. Health inspects and licenses Intermediate Care Facilities, and at the same time, those ICFs which provide MH/MR/DD services in a nursing home setting are reviewed by the Commission on the Aging through their Care Review process. Federal accountability regulations must be met for Title XIX, block grants and purchases of service. Since so many are involved, we will focus primarily on the mechanisms addressed by the reorganization.

In creating the Division, the reorganization assigned responsibility to them for the development of MH/MR service standards for CMHC, CCF, and other providers; these responsibilities include inspection and review authority, report of results and enforcing accountability.

Community Mental Health Centers. The reorganization legislation set forth the duties of the Division and the Commission to establish and enforce standards for the Community Mental Health Centers. This included transferring and strengthening responsibilities and authorities previously granted to the Iowa Mental Health Authority. The legislation required that local services funded by the Community Services Fund meet accreditation standards, where appropriate. These standards were intended to guide in the development of CMHC services as well as define their accountability requirements. In order to qualify for state or federal funds as a mental health center, a center must be accredited by the Division under the CMHC standards. The Commission will accept accreditation by the JCAH in lieu of this.

County Care Facilities. Chapter 225C mandates the adoption of standards for care of and services to mentally ill or mentally retarded persons in county care facilities and requires the director of the Division to recommend and enforce these standards. The standards are to be written in cooperation with the Department of Health for the purpose of developing an accreditation process for services at this level of care. Pursuant to Chapter 135C of the Code of Iowa, the Department of Health has responsibility to review and license all health care facilities in the state. This includes all ICFs and RCFs as well as those facilities specifically dealing with the mentally disabled. Responsibility for inspection of county care facilities lies with the Department of Health. The Reorganization legislation clarified and strengthened the Division's authority to remove residents of any CCF not in compliance with standards or failing to adequately meet the needs of residents. It required reporting of CCF inspection results to county supervisors, coordinating or advisory committees, the CCF administrator, Commission on the Aging and the Division.

Review of Current DHS Standards. The reorganization requires the review of standards employed by the Department of Human Services for licensing facilities which provide services to the mentally disabled. These facilities include day programs in hospitals and work activity centers, among others. The Division of MH/MR/DD works with the Division of Social Services to identify standards that address the special needs of the mentally disabled, and to refine and modify the guidelines governing the services proved under purchase of service agreements.

Other Providers. The Commission is required to adopt standards for the maintenance and operation of public or private facilities offering mental health or mental retardation services which are not subject to licensure or accreditation by Health or the DHS. Such providers include the private social service organizations, day treatment programs, and diagnostic/assessment services.

Analysis of Standards and Use by Providers

The CMHC standards have been implemented by the rules filed pursuant to the Administrative Procedures Act and became effective in October 1982. They address the areas of governance, administration, services, and review and evaluation of centers. The inspection surveys include: (1) interviewing clients; (2) interviewing staff and boards of directors; (3) examining the physical plant; (4) observing staffings and (5) inspecting client records. Staffing and client records document client needs, diagnosis, treatment plans and progress.

As of this writing, County Care Facility standards have not been developed. In the initial meetings held to develop these standards, the Division and Health decided to go beyond the scope of the law and develop not only CCF standards, but standards for all residential facilities servicing the mentally disabled. The two departments agree that new standards need to be developed, but no further action has been taken to facilitate meeting the mandate.

The reorganization has caused some confusion by assigning different areas of enforcement of CCF standards to both the Division and to Health. Chapters 225C.4(s) and 227C.2 and .4 of the Code of Iowa appear to be in conflict. The first assigns enforcement of CCF standards to the Division, while the latter deletes this enforcement responsibility while assigning inspection responsibilities to Health.

Current DHS standards are reviewed by the Division as an ongoing process. Standards for "other providers" have been developed and are now going through the administrative rules process. The Division estimates these standards to be in effect by December, 1984. The legislation does not, however, provide clear authority for review and evaluation of these providers to determine compliance with the standards.

To assess the efficacy of the quality assurance mechanisms currently in place, MH/MR/DD service providers were surveyed concerning their use and satisfaction with standards, inspections, and quality assurance as a whole. Service providers utilize a number of different state and federal standards. Required standards, especially those that insure funding, are used most often, i.e. CMHCs use CMHC standards most, while RCF/MRs use RCF standards most. However, as illustrated in Exhibit 15, a variety of standards are consulted or implemented to develop policy, improve service delivery and/or improve accountability.

Seventy-two percent of the providers we surveyed serve multiple populations. That is to say, they serve mentally ill clients, mentally retarded clients and developmentally disabled clients, or they serve clients who have multiple disabilities. Providers who serve multiple populations may have to utilize a variety of different service standards to address all the needs of their diverse populations.

EXHIBIT 15

USE OF STANDARDS BY VARIOUS PROVIDERS

STANDARDS	PROVIDERS: CMHC	ICF/MR	RCF	RCF/MR	HF	WAC	YRF	DLF	OTHERS
CMHC	X		*	*	*	*			*
ICF	*	*	*	*	*				
ICF/MR		*	*	*	*				
RCF	*		X	X	*				
RCF/MR	*		*	*	*	*			
ACMR	*		*	*	*	*	*	*	
JCAH/Psych.	*				X		*		*
CARF	*		*	*	*	X		*	
IP of S	*	*	*	*	*	*	X		*
IDSA	*		*	*	*			*	
CWL				*	*	*	*		*
CASFC				*	*	*	*		*
OTHER	*		*	*	*	*	*	*	

X = Most Often Used
* = Also Use

CMHC Community Mental Health Centers
MR for the Mentally Retarded
CARF Council on the Accreditation of Rehabilitation Facilities
DLF Dual Licensee Facilities
ACMR Accreditation Council for Services for the Mentally Retarded

ICF Intermediate Care Facilities
JCAH Joint Council on the Accreditation of Hospitals
IP of S Iowa Purchase of Services
CWL Child Welfare League

RCF Residential Care Facilities
HF Hospital Facilities
WAC Work Activity Center
IDSA Iowa Dept. of Substance Abuse
CASF Council on the Accreditation of Services for Families and Children, Inc.

Not all providers of similar services are governed by the same standards. In those areas for which standards are developed specific to the population being served, CMHC, work activity centers, psychiatric hospitals, etc., providers use the same standards. But in facilities for which standards have not been as clearly developed to address the specific programmatic needs of clients with differing disabilities (licensed health care facilities which serve mentally ill or retarded) providers consult those standards which seem most appropriate to the needs of their clients.

For example, standards for service to the mentally retarded have been developed for ICF/MRs and RCF/MRs, but standards for the mentally ill served in such facilities have not been delineated. Those facilities serving multiple populations are lacking specific guidelines to assure quality service to the mentally ill and/or developmentally disabled. Providers indicated that RCFs serving multiple populations are governed by standards pertaining to the physical structure of the building only; there are minimum program

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requirements. Nothing in these standards addresses the special programmatic needs of the clients served, although providers indicate that they are trying to meet these needs by using standards other than those which license them.

Standards promulgated by agencies of the State of Iowa are among those used by service providers. Of eight sets of standards identified in the survey, respondents assessed the extent to which the standards and inspection process are appropriate to their agency, assist in improving accountability, and improve quality assurance. Exhibit 16 identifies the standards and indicates the relative ratings they received by providers who use them most often. Ratings are on a 1 to 5 scale with 1 being "to no extent" and 5 being "to a great extent".

EXHIBIT 16

EVALUATION OF IOWA STANDARDS

	Iowa Standards			Iowa Inspection		
	Appropriate for Agency	Adequate for Accountability	Adequate for Quality	Appropriate for Agency	Adequate for Accountability	Adequate for Quality
OMC	4.1	3.9	3.2	4.1	4.0	3.3
ICF	4.0	4.3	3.8	4.0	4.3	3.7
ICF/MR	5.0	4.3	4.0	4.5	4.3	4.0
RCF	4.3	4.1	3.5	3.9	3.9	3.6
RCF/MR	3.8	3.4	3.2	3.1	2.9	2.8
Purchase of Service	4.1	3.7	3.4	3.8	3.8	3.6
Child Care Facility	4.5	4.0	3.8	4.5	4.0	3.8
Substance Abuse	2.5	2.7	2.0	2.7	2.7	2.0

The most marked observation from this data is that for both the standards and the inspection process, their appropriateness to the agency rated highest, while their assurance of quality service was lowest.

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SECTION VII

FINDINGS AND RECOMMENDATIONS

System Description Findings

The four primary policy-makers in the MH/MR/DD system, the Commission, the DD Council, the county boards and other state agencies, all have varying degrees of responsibility for decision-making, goal-setting, monitoring and capacity-building. Based on a survey of organizations within the MH/MR/DD system, county boards are perceived to be the main decision-makers in the system and this is due, primarily, to the role they play in local planning and funding. The Commission of MH/MR/DD is the primary goal-setter in the system, although goal setting is high among county boards, other state agencies and the DD council as well. Part of the Division's responsibility to coordinate is to assure consistency within the goals set by the key policy-makers. The decision-making and goal-setting functions within the system are strong.

Not as strong are the monitoring and capacity building functions performed by these policy-makers. Monitoring can be both a formal process of quality assurance and fiscal accountability, and an informal process of feedback and assessment and advocacy. None of the policy-makers receive high marks for monitoring. The county boards are perceived as doing the greatest amount of monitoring and are subject to the most monitoring by others within the system. The poorest marks were in the areas of capacity building, which include education and information as well as training and technical assistance to improve management and service quality. County boards and the DHS staff receive most of the training provided by any of the four policy-makers.

RECOMMENDATION

1. Policy makers and the Division should focus on developing a system for both formal and informal monitoring and capacity-building.

Planning Findings

Creation of the county planning process is viewed positively. Counties report that the general allocation application is a valuable tool in planning. The Comprehensive State Plan is not as useful. From our analysis, the Plan does an adequate job of describing the system, but does not provide a useful delineation of goals, objectives, actions steps and responsibility assignments for use by organizations within the system.

The Division is mandated to establish and maintain a data collection and management information system oriented to the needs of patients, providers, the department, and other programs or facilities. We found their information inadequate to answer questions concerning service availability, levels of services available and actual accessibility of those services. Their "system" is fragmented, poorly organized, incomplete, and for the most part, not automated.

RECOMMENDATION

2. Revisions of the Plan should de-emphasize system description and provide a clear, concise delineation of goals for the system, objectives, actions steps and assignments of responsibility to better guide and coordinate participants within the MH/MR/DD system.

3. The Division should improve the data collection and management information system for convenient use by system participants, focusing particular attention on information regarding service availability, level and accessibility. In addition, the Division needs to reach a point of standardizing and finalizing definitions, forms, and tools for them to be effective measures of system change.

Coordination Findings

Coordination is an important feature of the reorganization legislation. Several mechanisms were designed to facilitate coordination, with the Division being assigned primary responsibility to coordinate activities and organizational relationships within the MH/MR/DD system. Yet, there are marked differences in the degree of coordination experienced by different organizations within the system. Despite high consensus on goals, patient advocates report lowest coordination with the Division. The highest degree of coordination exists between the Division of MH/MR/DD and other divisions of the DHS.

Respondents failing to answer questions regarding coordination expressed that they perceived no joint activities between their organization and the Division on which to make judgement. Coordination requires a variety of interactions and activities between the Division and system organizations. This perceived lack of joint activities signals a missed opportunity for the Division to facilitate greater degrees of coordination.

Five factors appear to be key for the Division to coordinate organizational activities within the MH/MR/DD system, regardless of the population an organization serves, the variety or complexity of the organization's involvement in the system, the existence of disputes between an organization and the Division or their degree of resolution, the frequency of contacts, or the degree of balance of power and trust and sympathy with the Division. Coordination is highest when 1) consensus is reached on the important needs of the MH/MR/DD population and the way services should be provided, 2) formalization of relationships are maintained between the Division and other organizations in the system, 3) the contacts between the Division and an organization are important to accomplish the organization's mission, 4) there is optimal symmetry in the transactions between the Division and other organizations creating reciprocal working relationships, and 5) an equalitarian communication style is maintained with organizations.

RECOMMENDATION

4. To optimize coordination between the Division and other organizations within the MH/MR/DD system, attention should be focused on four of five key factors. Specific interorganizational committees should be created which integrally involve patient advocates and advocacy organizations in the planning and decision-making processes of the system.

The Division needs to work toward or negotiate greater consensus on the goals of the MH/MR/DD system and the ways in which those goals will be attained. An equalitarian communication style and a better balanced flow of resources between the Division and participating organizations should be optimized and maintained.

Fiscal Findings

It appears that there is uniformity of counties' property tax burden and financial effort. Per capita local expenditures and levy rates have been approximately equal across the state from 1977 through 1983.

Increases to the Community Services Fund by the state have not been of significant proportion to local property tax revenues to influence the local system. Although the services fund has committed a million dollars more each of three years, counties still raise the largest portion of funds for local services.

Although the dollar amounts expended locally for MH/MR/DD services continues to increase, an adjustment for inflation shows that no new real dollars are entering the system. Expenditures are merely keeping pace with inflation; more money is not being committed to fund the system.

RECOMMENDATION

5. Reliance on local property tax for MH/MR funding limits the development of a comprehensive array of services in smaller rural counties. If the goal is to reduce the heavy reliance on local property tax by smaller rural counties two options exist: 1) The General Allocation formula should be adjusted to provide more dollars to small counties which have the greater service deficiencies, or 2) more money should be committed to the Community Services Fund to provide a greater proportion of state to local dollars statewide.

Range of Services Findings

The ongoing change of service definitions by the Division has made it difficult to track changes in service availability. In addition, the Division has little information to determine the level and accessibility of services or the general availability of services.

While most counties report the existence of more local services now than they did in 1979, counties with low median income and low population still report large gaps in services. Transitional services such as emergency, local inpatient, intermediate care/partial hospitalization and residential services are areas of greatest service deficiency.

Populations at the MHIs and SHSs are decreasing. Admission rates and lengths of stay are both on the decline. But evidence whether preliminary diagnostic evaluations facilitate deinstitutionalization is uncertain; it is difficult to assess a specific cause in light of closure of institutions, transfer of residents to other state and local institutions, changes in funding and increased awareness generally.

Based on data available, deinstitutionalization is not significantly affected by the range of services available locally. There appears to be heavy reliance on services provided in a more restrictive environment at the local level. This may be due to the lack of transitional services needed to facilitate local deinstitutionalization.

RECOMMENDATION

6. The Division should develop a clear strategy for expanding the range of services to rural counties, particularly those with lower populations and lower property values which experience the highest levels of service deficiency. Previously recommended changes in funding help to address the problems associated with "economies-of-scale" in rural areas. Greatly expanded monitoring and capacity-building are necessary by the Division to assist local planners in developing the necessary skills for initiating new and alternative services locally.

Quality Assurance Findings

The legislation mandated that the MH/MR/DD Commission and Division develop and adopt standards for community mental health centers, county care facilities, and other providers. Rules have been promulgated for CMHC and other providers, but are yet to be developed for county care facilities.

The Division is mandated to establish suitable standards of care, treatment and supervision of mentally disabled residents of CCFs and the Department of Health is assigned enforcement of these and other standards. To date, these standards have not been established nor have enforcement procedures been implemented. In their attempt to be more comprehensive and have such standards apply to all other residential facilities, the Division and Department of Health have expanded the mandate beyond a manageable scope. Neither agency has been able to distinguish their responsibilities for such activities to meet the mandate. A conflict between two Code of Iowa chapters compounds the problem. Chapter 225C.4(s) requires the Division to recommend and enforce standards, while Chapter 227.2 and .4 requires Division recommendation of standards and Health Department inspection, but deletes the Division's enforcement responsibility.

Within the MH/MR/DD quality assurance system, standards are being applied based on the physical and safety needs of residents rather then on the programmatic and treatment needs for the variety of disabilities of clients served by the facility. For example, licensed health care facilities standards focus on health and safety requirements rather than treatment needs of the mentally ill or retarded who may be in residence. Standards may not, in such cases, appropriately address the needs of all clients served by some facilities.

RECOMMENDATION

7. The General Assembly should remove the conflict that exists between Chapters 225C.4(s) and 227.2 and .4 to clarify standards and enforcement responsisibilities for the Division and the Department of Health.

8. The Division and the Department of Health should proceed with the promulgation and implementation of standards for County Care Facilities.

9. The Division and Department of Health should develop, for the General Assembly, proposed legislation which requires licensing of ICFs and RCFs appropriate to the levels of care of the mentally disabled they serve. Included in this legislation should be a revision of Division responsibilities to include the recommendation and transmittal to the Health Department, of standards for the treatment and care of the mentally ill, the mentally retarded and the developmentally disabled in such licensed health care facilities.

EXECUTIVE REVIEW RESPONSE

OF THE

THE DEPARTMENT OF HUMAN SERVICES

Iowa
Department
of
Human Services

HOOVER BUILDING DES MOINES, IOWA 50319

TERRY E. BRANSTAD
GOVERNOR

Michael V. Reagen, Ph.D.
Commissioner

September 20, 1984

Dennis C. Prouty, Director
Legislative Fiscal Bureau
State Capitol Building
L O C A L

Dear Mr. Prouty:

I am enclosing our written response to the Program Evaluation of the Reorganization of Mental Health, Mental Retardation, and Developmental Disabilities System.

I believe the findings and suggestions to be well worth careful review. I also wish to share my appreciation for the courteous and professional manner of your staff.

Sincerely,

Michael V. Reagen, Ph.D.
Commissioner

MVR:bb

Enclosure

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September 20, 1984

RESPONSE OF THE DEPARTMENT OF HUMAN SERVICES TO
THE REPORT OF THE LEGISLATIVE FISCAL BUREAU EVALUATION TEAM

The Iowa Department of Human Services has reviewed with great interest the program evaluation of the reorganization of the state's Mental Health/Mental Retardation/Developmental Disabilities (MH/MR/DD) system and appreciates the insights that are afforded by this study, both to this agency and to the General Assembly. Indeed, the findings and recommendations of the Fiscal Bureau's report are certainly worthy of further exploration and consideration by the Legislature and by all councils, boards, local officials, advisory and advocacy groups, and community participants whose involvement will be necessary for implementation of further improvements in the MH/MR/DD system.

The recommendations of the evaluation are very general, necessarily so in light of the complex and de-centralized nature of the MH/MR/DD system. Refining the recommendations into specific proposals--legislative, administrative, and cooperative--will require careful deliberation. To that end, the following remarks are offered as an addendum to the report.

Additional Information on Reorganization

We would suggest that additional measurements of the functioning of the Division of MH/MR/DD be included in final assessments of reorganization. For example, since reorganization, the following changes have taken place: the services of community mental health centers have expanded into a total of 96 counties, MH/MR coordinating and advisory boards have been created in 99 counties, and more federal dollars have been obtained for community based mental health services. For the first time since reorganization, county coordinating boards are beginning to systematically collect data and plan for community based services. These very significant accomplishments are not detailed in the statistical measurements of the study, and therefore, do not provide the reader with a historical perspective. Even more before-and-after reorganization data could help the reader determine the extent to which service delivery evolved since the time the legislation was enacted.

Recent Developments

Recent developments will be very helpful in resolving some of the deficiencies or in realizing some of the recommended improvements cited in the study. Assistance received from the federal Mental Health Manpower grant has enabled the Division to provide active on-site program monitoring and more local training. These activities were initiated after the data for the study was collected. Capacity-building efforts will be enhanced as we fill a specialist position, add a field person to the Community Support Services (CSS) project to work with local decision-makers on expanding services for Chronically Mentally Ill (CMI) clients, and (if possible) fill two vacancies in the areas of community capacity building and provider accreditation by the end of FY '85.

Minor Corrections

A list of minor corrections in data or terminology in the draft of the report has been forwarded to the Bureau for final editing.

Alternative Conclusions

The Department does have a different understanding of the role of the Developmental Disability (DD) Council as well as the intent of the Legislature in establishing the state funding.

First, the report states that the DD Council is perceived as making decisions of little importance and does the least amount of monitoring. Since no direct involvement is legislated between the Council and county boards, and the Council has been funding very few providers or advocacy agencies over the past two years, the perceptions are not surprising. However, it should be noted that direct comparison with key decision-makers who have different functions and different statutory bases are being made. The DD Council has a very important function which should not be overlooked by a ratings comparison on other functions pertinent to different boards, councils, or agencies. Relative to its special responsibilities, and perhaps increasingly so in the future, the DD Council is an important part of a coordinated system.

Second, the report several times states that one of the functions of reorganization is to relieve the property tax burden on the counties. As understood by the Department of Human Services (DHS), the intent of the Legislature was to have the state enter into a partnership with the counties in sharing the burden of MH/MR/DD expenditures. Along with increasing the uniformity of financial effort and the property tax burden to the counties, the Legislature's intention was to bring an equitable fiscal arrangement between the state and the counties. However, no conclusions should be drawn that as the state moved into funding services that the counties would decrease its efforts, thereby lowering local taxes. Indeed, as the state becomes ever more the partner of the counties in MH/MR/DD services, the counties might increase and expand there own efforts to serve the special needs of their citizens. If reorganization has not resulted in lower property taxes, that is not a measure of lack of success. Rather, if reorganization has improved the efficacy and efficiency of dollars expended in a state/local partnership, and if the partnership itself has increased fairness and uniformity across the system, then reorganization has met the goal.

Response to Criticisms

The Department of Human Services concurs with the findings of the evaluation team that improvements need to be made in several areas of established operation.

- DHS needs to interact more actively and creatively with patient advocates. We will also encourage local decision-makers and providers to increase their interaction with advocates.

- Issues noted in Section VI, Quality Assurance, relative to establishing and monitoring standards, are well taken by the Division.

- DHS agrees that the community mental health and mental retardation service system is in dire need of a comprehensive data system. Significant improvements have been made in the data system for the state institutions, but no comprehensive system exists for community mental health and mental retardation service system.

- The level of usefulness of the state plan document to local providers and MH/MR coordinating and advisory boards will be examined as the next three-year plan outline is developed.

Final Comments

The Division will continue its coordinating efforts as the many individuals and organizations in the MH/MR/DD system move towards new phases of program enhancement. We extend our thanks to the professional staff of the Bureau for the contributions this study will make to public discussion of MH/MR/DD concerns. We look forward to working with all participants in refining the recommendations into specific proposals. Inspite of a flat economy, limited resources, and small staffs, human service agencies at the state and local levels have accomplished much in coordinating services. As the report indicates, much is yet to be done.

References

Books, Journals

Barrett, Jon H.
1970 Individual Goals and Organizational Objectives: A Study of Integration Mechanisms. Ann Arbor, Michigan: Center for Research on Utilization of Scientific Knowledge.

Bowers, David G.
1976 Systems of Organization: Management of Human Resource. Ann Arbor, Michigan: The University of Michigan Press.

Brown, Warren B. and Dennis J. Moberg
1980 Organization Theory and Management: A Macro Approach. New York: John Wiley & Sons.

Cox, Gary B., Timothy R. Brown, Paul D. Peterson and Maureen M. Rowe
1982 "A Report on a State-Wide Community Mental Health Center Outcome Study." Community Mental Health Journal. Vol. 18 No. 2. Summer. pp. 135-150.

Cronbach, Lee J.
1982 Designing Evaluations of Educational and Social Programs. San Francisco: Josey-Bass Publishers.

Dellario, Donald J. and William A. Anthony
1981 On the Relative Effectiveness of Institutional and Alternative Placement for the Psychiatrically Disabled. The Journal of Social Issues, Vol. 37, No. 3, pp. 21-33.

Estroff, Sue E.
1981 "Deinstitutionalization: A Socio cultural Analysis. The Journal of Social Issues." Vol. 37, No. 3, pp. 116-132.

Evan, William M.
1976 Organization Theory: Structures Systems, and Environments. New York: John Wiley & Sons.

Felton, Barbara J. and Mary Beth Shinn
1981 "Ideology and Practice of Deinstitutionalization." The Journal of Social Issues, Vol. 37, No, pp. 158-172.

Finsterbusch, Kurt and C. P. Wolf
1981 Methodology of School Impact Assessment. Stroudsburg, PA: Hutchinson Ross Pub. Co.

Flaherty, Eugenie Walsh and Charles Windle
1981 "Mandated Evaluation in Community Mental Health Centers: Framework for a New Policy." Evaluation Review, Vol. 5, No. 5, October, pp. 620-638. (Sage Pub.)

Frumkin, Michael, Allen Imershein, Richard Chackerian, and Patricia Morton
1981 "Evaluating State Level Integration of Human Services." San Francisco: National Conference on Social Welfare. (June)

Fulmer, Robert M.
1979 Management and Organization: An Introduction to Theory and Practice. New York: Barnes & Noble Books.

Hocking, R.R.
1972 "Criteria for selection of a subset regression: which one should be used." Technometrics 14: November.

Jacobson, Perry E., Jr.
1976 Introduction to Statistical Measures for the Social and Behaviorial Sciences. Hinsdale, Illinois: The Drden Press.

Kerlinger, Fred N.
1973 Foundations of Behaviorial Research (2nd ed.) New York: Holt, Rinehart & Winston.

Kiesler, Charles A.
1982 "Mental Hospitals and Alternative Care: Noninstitutionalization as Potential Public Policy for Mental Patients." American Psychologist. April, pp. 349-360.

Kohout, Frank J.
1974 Statistics for Social Scientists: A Coordinated Learning System. New York: John Wiley and Sons.

Lucas, Henry C., Jr.
1975 Why Information Systems Fail. New York: Columbia University Press.

Mavritte, Harold E.
1981 "Community Care of the Mentally Ill: The California Experience" San Francisco: National Conference on Social Welfare (June).

McDowall, David, Richard McCleary, Erroll E. Meidinger, Richard A. Hay, Jr.
1980 Interrupted Time Series Analysis. Beverly Hills: Sage Publications.

McGuire, Thomas G.
1981 Financing Psychotherapy: Costs, Effects and Public Policy. Boston: Ballinger Publishing Company, pp. 3-11.

Nie, Norman H., C. Hadlai Hull, Jean G. Jenkins, Karin Steinbrenner, Dale H. Bent
1975 SPSS: Statistical Package for the Social Services. New York: McGraw Hill.

Osborn, Richard N., James G. Hunt and Lawrence R. Janch
1980 Organization Theory: An Integrated Approach. New York: John Wiley & Sons.

Ostrom, Charles W., Jr.
1978 Time Series Analysis: Regression Techniques. Beverly Hills Sage Publications

Rutman, Irvin D. (ed)
1981 Planning for Institutionalization: A Review of Principles, Methods and Applications. Human Services Monograph Series No. 28: Project Share, September.

Scull, Andres
1981 "Deinstitutionalization and the Rights of the Deviant." The Journal of Social Issues. Vol. 37, No. 3, pp. 6-20.

Sheinfeld, Sherri N. and Thomas W. Weirich
1981 "Ideology and Performance: Service Delivery in a Community Mental Health Center." Public Administration Review, Vol. 41, No. 1, Jan/Feb., pp. 63-72.

Shinn, Marybeth and Barbara J. Felton
1981 "Institutions and Alternatives." The Journal of Social Issues, Vol. 37, No. 3, pp. 1-5.

Summer, David E. CSG.
1980 "Patients Released to Communities: Deinstitutionalization - Does It Work? State Government News, October, pp. 3-4.

Sweet, William
1982 "Mental Health Care Reappraisal." Editorial Research Reports. Vol. II, No. 7, August 20, pp. 611-632.

Van de Ven, Andrew and Diane L. Ferry
1980 Measuring and Assessing Organizations. New York: John Wiley & Sons.

Talbott, John A., M.D.
1980 "Toward a Public Policy on the Chronic Mentally Ill Patient - Delivery of Services." American Journal of Orthopsychiatry 50(1), January, pp. 43-53.

Test, Mary Ann
1981 "Community Treatment of the Chronically Mentally Ill: What is Necessary?" The Journal of Social Issues, Vol. 37, No. 3, pp. 71-86.

Wenen, Carol A.B.,
1981 "Control: The Myths of Deinstitutionalization." American Behaviorial Scientist, Vol. 24, No. 6 (July/August).

Whitmer, Gary E. LCSW.
1980 "From Hospitals to Jails: The Fate of California's Deinstitutionalized Mentally Ill." American Journal of Orthopsychiatry 50(1) (January), pp. 65-75.

Willetts, Ruth
1980 "Advocacy and the Mentally Ill." Social Work. September, pp. 373-377.

Government Documents

Ben-Dashan, Tal, Lanny Morrison and Martin Kotler
1981 Community Support Program Performance Measurement System Development and Short-term Evaluation Final Report. Submitted to Office of the Assisstant Secretary for Planning & Evaluation DHHS. by Marco Systems, Inc., May.

Davis, Richard and Virginia Sheffield
1979 County Mental Health Fund Study and Supplement; Des Moines, Iowa: Legislative Fiscal Bureau.

Freyer, Thom D., M. Dwayne Ferguson, Binnie LeHew, Nancy Cramer
1983 Iowa Commission on the Aging: Coordination of Interagency Planning Projects. Des Moines, Iowa: Legislative Fiscal Bureau.

Freyer, Thom D., Virginia Sheffield, and Deb Westvold
1980 Mental Health Reorganization: An Analysis of Selected Funding Provisions; Des Moines, Iowa: Legislative Fiscal Bureau.

Governor's Task Force on Mental Health
1978 Report to Governor. Des Moines, Iowa: Office for Planning and Programming.

Hargreaves, Wm. A., Clifford Attkisson and James E. Sorenson
1977 Resource Materials for Community Mental Health Program Evaluation. DHEW Pub. (ADM), pp. 79-328.

Hearings before the Subcommittee on the Handicapped of the Committee on Labor and Human Resources, U.S. Senate 97th Congress.
1981 1st Session on Oversight on the Effects of Deinstitutionalization of Mentally Retarded Citizens. April 14-15, Hartford, Conn.

House File 701 Joint Subcommittee of the Senate and House Committees on Human Resources
1979 Final Report. Des Moines, Iowa: Iowa Legislative Council.

Human Services Research Institute
1978 The Iowa Mental Health System: A Firm Foundation for Change; Des Moines, Iowa: Legislative Fiscal Bureau.

Humphreys, George G.
1979 Preliminary Data Collected for Project PRESS Review of Oklahoma Community Mental Health Centers, December.

Iowa Department of Social Services
1979 Administration of State Mental Health Programs: A Cost Study; Des Moines, Iowa: Iowa Dept. of Social Services.

Iowa Mental Health Advisory Council
1979 Interim Report and Recommendations. ; Des Moines, Iowa: Iowa Mental Health Advisory Council.

Legislative Fiscal Bureau
1980 Mental Health Reorganization: An Overview of the Fiscal Impact of House File 701 and Recommended Amendments. Des Moines, Iowa: Legislative Fiscal Bureau.

Legislative Fiscal Office (Washington).
1981 Performance Audit Report: Department of Mental Health September.

Mannino, Fortune V. and Beryce W. MacLennan
1978 Monitoring and Evaluating Mental Health Consultation and Education Services. DHEW Pub. (ADM), pp. 77-550.

Morrissey, J.P.; Hall, R.H.; and Lindsey, ML
1982 Interorganizationtional Relations: A Sourcebook of Measures for Mental Health Programs. Mental Health Service System Reports, Series BN No 2: Needs Assessment and Evaluation, DHHS Pub. #(ADM)

Segal, Julius (ed.)
1975-7 Research in the Service of Mental Health. DHEW Pub. (ADM), pp. 77-237.

Sheffield, Virginia and Thom D. Freyer
1980 Correlation Analysis: Median Family Income, Assessed Valuation, Density, and Per Capita Mental Health Expenditures; Des Moines, Iowa: Legislative Fiscal Bureau.

Westvold, Deb, Thom D. Freyer, and Virginia Sheffield
1980 Mental Health Reorganization: A Study of Service Availability; Des Moines, Iowa: Legislative Fiscal Bureau.

Windle, Charles A. (ed)
1979 Reporting Program Evaluations: Two Sample Community Mental Health Center Annual Evaluation Reports. DHEW Pub. (ADM), pp. 79-607.

Legal

Chapter 78, Laws of the 69th General Assembly, 1981 Session
"Mental Health, Retardation, and Developmental Disabilities"

Chapter 1117, Laws of the 69th General Assembly, 1982 Session
"Mental Health Reorganization"

Chapter 1244, Laws of the 69th General Assembly, 1982 Session
"Substance Abuse Services and Licenses"

Chapter 1260, Laws of the 69th General Assembly, 1982 Session
"Omnibus Supplemental Appropriations"

Chapter 225c, 1983 Code of Iowa
"Mental Health, Mental Retardation, and Developmental Disabilities"